LOS ANGELES COUNTY
HIV PREVENTION PLANNING COMMITTEE (PPC)
A Select Committee of the Commission on HIV Health Services
600 South Commonwealth Avenue, 6th Floor•Los Angeles CA 90005-4001

MEETING SUMMARY
Thursday, March 3, 2005
1:00 PM - 5:00 PM
St. Anne's Maternity Home - Foundation Conference Room
155 N. Occidental Blvd.-Los Angeles, CA 90026

MEMBERS PRESENT		ABSENT
Jeff Bailey	Mario Pérez	
Vanessa Talamantes*	Chi-Wai Au	Sergio Aviña
Diane Brown	Jose Roberto Barahona*	Richard Browne
David Giugni*	Jeffrey King*	Gordon Bunch
Elizabeth Mendia	Veronica Morales	Manuel Cortez
Ricki Rosales*	Kathy Watt*	
Freddie Williams*	Richard Zaldivar	

* Denotes present at one (1) of the roll calls

OAPP STAFF PRESENT
Arthur Durazo, Elizabeth Escobedo, John Mesta, Jane Rohde, Cheryl Williams

I. ROLL CALL
Roll call was taken at 1:00 PM.

II. COLLOQUIA PRESENTATION
Dr. Rose Veniegas, Center for HIV Identification, Prevention and Treatment Services, welcomed and introduced Dr. Paul Robert Appleby the March, 2005 Colloquia Presenter. Dr. Paul Robert Appleby's presentation titled The Virtual Sex Project – An HIV Intervention was presented to the PPC. The Project Objectives are to develop a new approach in the intervention of HIV that is easily accessible, cost-effective, and better than current interventions. A major goal of this project is to reduce the rates of sexually risky behavior and to promote safer sexual behavior among men who have sex with men. Particularly, among young Latino, African-American and White males who represent at-risk populations as evidenced in the resurgence in rectal gonorrhea and other sexually transmitted diseases. A brochure was distributed.

The Problem
- Many MSM have become desensitized and, as a result, have "tuned out" to traditional HIV prevention messages.
- Novel approaches to HIV prevention are needed to recapture the attention of young MSM.
- Such an approach should be feasible, effective, engaging, and informed by HIV prevention research.
- The use of interactive video (IAV) technology is a possible solution.

Interactive Video (IAV)
- IAV allows the participant to make "real life" decisions in a controlled virtual social environment.
- The participant assumes the role of the main character.

- The participant gets to make choices which guide the narrative of the video (i.e., what happens next)
- Throughout the course of the video, participants have the option of seeking peer guidance when faced with a difficult decision. Additionally, these "guide" characters intervene with positive feedback or mild admonishment when necessary.

Advantages to Interactive Video

- Interactive quality allows for a more individualized/engaging experience.
- Does not suffer from slippage in delivery of message.
- Characters providing information can be identified with and related to by our target audiences.

Developing an IAV for Risky Sexual Behavior

- Incorporate methods that have been effective in other interventions…
    - Modeling of successful safer sex negotiations
    - Rehearsal of safer sex negotiation techniques at critical points in a sexual sequence
    - Training in self-control and self-instruction approaches for recognizing and dealing with risky situations

Why Be Sexually Explicit?

- State Dependent Learning
- Information learned in a particular psychological or physiological state is more likely to be remembered when in that same psychological or physiological state later.
- Video is sexually arousing and information learned in this aroused state should transfer to real life sexual situations more readily.

Additional Goals

- Cultural Tailoring and Sensitivity (3 versions of IAV)
    - African-American
    - Latino
    - Caucasian
- Target Age Group
    - 18 – 30 years
- Development of a sustainable, modular template for a variety of virtual learning environments

Design

- A randomized longitudinal design will examine immediate and long-term changes in sexual behavior among the 600 participants.
- Conditions
    - Control
    - Interactive Video
    - Non-Interactive Video
    - One-on-One HIV Prevention Counseling

Variables of Interest

- Reported Sexual Behavior (e.g., Unprotected Anal Intercourse)
- Involvement of participants
- Engagement
- Behavioral Intentions
- Social Norms & beliefs
- Sexual Arousal
- Affect
- Knowledge
- Identification with Main Character
- Relationship with Peer Guides

Assessment

- Screened for eligibility – Visit 1

    - Baseline Survey
    - Intervention (4 conditions)
    - Immediate Post Test
- From Home
    - 12 Weekly Phone-ins/Log-ins
- Visit 2 (90 days after Visit 1)
    - Follow-Up Survey
    - If in control group, receive intervention at Visit 2

The Latino version of the Virtual Sex Project Interactive Video was played. The audience participated by choosing some of the options.

Participants will be compensated for the completion of the research component over a 3-month time period.

$ 50	1st Visit
$ 60	Phone-In Surveys ($5 per call [12 calls] = $60 max
$ 50	2nd Visit
$160	**Total compensation for completion of all research components**

Additionally, participants may earn a maximum $30 for recruiting 3 participants ($10 per recruited participant). *NOTE: Compensation of $10 per recruit will be issued upon recruit's completion of all research components*.

Gay Men's Interactive Video – The interactive video (IAV) was pioneered and developed by researchers based upon psychological theories as an interactive behavioral intervention for risky sexual behavior. The video provides training in cognitive and social/behavioral skills in negotiating safer sex. It allows participants to actively engage by making choices in how the video progresses. The video provides interactive learning in a realistic and emotionally textured environment. This learning environment, it is hoped, will be more effective than traditional HIV counseling at reducing HIV risk behavior. Three versions of the interactive video were produced, one for Latino, Caucasian and African American participants. Each version was written to appeal to hip MTV generation audiences (tailored to be culturally appropriate for each ethnic group).

A copy of the presentation is on file.

Contact Information
University of Southern California – Annenberg School of Communication
University Village
3375 South Hoover Street, Suite E209
Los Angeles CA 90007
Dr. Lynn Miller, Principal Investigator
Dr. Paul Robert Appleby, Co-Investigator
(213) 821-1117

QUESTION: (Audience) What theoretical model are you using?
ANSWER: (Dr. Appleby) Basically, we wanted to manipulate certain variables that have been shown in the literature to contribute to risky behavior or safer sex behavior, so there is a good deal of behavior modeling that is part of the interactive video.

QUESTION: (Jeffrey King) In terms of the sex scenes, was there a concern when putting this video together as it relates to the sex scenes? Where there some things you had to do?
ANSWER: (Dr. Appleby) We did not show any buttock, we did not show any genitals and most of the video was shot from the waist up. The anal sex scenes were shot very carefully so as not to expose those regions.

QUESTION: (Richard Zaldivar) Have you pursued any of this kind of work in Commercial Sex Venues?
ANSWER: (Dr. Appleby) Yes, we did. In our piloting phase, we went to several commercial sex venues. For many of the bathhouses, we found there was an older (age 30 and older) cohort.

QUESTION: (Richard Zaldivar) Who are your funders and what is the response to this?
ANSWER: (Dr. Appleby) NIH. NIH has been very supportive.

QUESTION: (Peter Sykes) How could this work at our clubs? Can we buy this?
ANSWER: (Dr. Appleby) The first thing we have to do is evaluate it and ensure its efficacy. We don't have any data yet to suggest whether it is an effective intervention or not. The first level of this is the study where we have a control group, we have an interactive video group and we have a traditional counseling group and we can evaluate outcomes based on which condition people are assigned to. If it were shown that the interactive video is effective, the next steps would be to distribute the video more widely.

QUESTION: When you say data, do you mean showing this to a group of people and having them rate it or are you talking about monitoring the behavior as it related to risk reduction over time?
ANSWER: Both, but the most important thing would be looking at the incidence of unprotected anal sex intercourse over the 90 day period following viewing the video.

QUESTION: (Rose Veniegas) If there are agencies that are here today that would like to serve as places where they could send their clients who might benefit from seeing this kind of information, do you have a sign-up sheet with you here today?
ANSWER: I brought some business cards. I can also make a quick sign-up sheet and have people do that.

QUESTION: (Diane Brown) Where can study participants are accessing the video?
ANSWER: We are finishing the training for our interventionist and interviewers. We will be starting data collection later this month. At this point, we have some venues where we have established relationships with and will be doing some venue-based sampling.

QUESTION: Regarding the study participants, are you going to be splitting them up between people who go to regular venues or sex venues as opposed to Internet users? Is there going to be a study on Internet users?
ANSWER: At this point, it is not part of the study design to do a comparison of those groups.

QUESTION: (Mario Pérez) Has a discussion on disclosure of HIV status been built in?
ANSWER: We have a HIV discussion of status option.

QUESTION: (Mario Pérez) In your evaluation, how will you control for participants expose to other HIV prevention services over the course of a longitudal study?
ANSWER: We can control for it, in the sense, we can ask about what studies people have been exposed and we can look at that statistically in a number of different ways; but other than that there is nothing built into the design to sample equal numbers of people that have been exposed to different interventions.

QUESTION: (Mario Pérez) What is the timeline for the evaluation results, do you think?
ANSWER: We will be collected data for the next 2½ years. Hopefully, we will have our full data analyzed within 3 years. We do have mini-studies built into the design, so there are smaller studies and smaller pieces of the data that we will be able to look at along the way.

QUESTION: (Mario Pérez) Hypothetically, if we were looking to launch this program locally, what would you need technologically to have in place in order to implement this?
ANSWER: All you need is a DVD Player and a television set in terms of playing the video. We set it up on a DVD platform, because that platform is very inexpensive (you don't need a computer to run it).

QUESTION: (Mario Pérez) So, you would sell the DVD for $9.99 or something?

ANSWER: We do not have any plans to sell the video. We need to ensure it is effective and if the video/DVD is effective, we would like to distribute it.

QUESTION: (Richard Zaldivar) Could you not use this internet based with a follow-up evaluation to that, then provide an incentive to the person who is reviewing the evaluation?
ANSWER: That is something we have been looking at, you will still need a broadband connection.

QUESTION: (Peter Sykes) Three years seems like a long time, is there a way to cut through that period?
ANSWER: We can do smaller evaluations, preliminary evaluations during that time but in terms of statistics you have to have a certain number of people enrolled in the study before you can make conclusions about whether something is effective.

QUESTION: Why were Asian Pacific Islanders (APIs) not included in this study?
ANSWER: When we went to get funding, the level of funding we were able to obtain allowed us to produce three videos. Essentially, each one of the videos was produced separately and had a separate budget and we looked at the CDC's statistics and looked at the three highest groups in terms of rates of new infections. The three groups that were the highest were Latino, African American and Caucasian and that was why the decision was made. If this project is successful, we may be in a position to get more funding and at that point it would be wonderful to produce a video that is appropriate for API.

QUESTION: Is it possible to address the API issue and there not being a API video by either adding a subtitle version or over dub, so that API's can be included in the project without having to make a new video?
ANSWER: Let's talk about that. Can you talk after the meeting?

QUESTION: Are there any kind of plans to create something like this in Spanish for Spanish speaking Latinos? In the development of the casting, was there any kind of research that indicated that models would deliver a message more so than anybody of a variety of shape and sizes in the community?
ANSWER: We did do some piloting on attractiveness and we showed pictures of models of different shapes and sizes to our pilot participants to get rating for attractiveness and what participants may want to see in a video.

III. REVIEW/APPROVAL OF MEETING AGENDA

The draft meeting agenda for March 3, 2005 was reviewed and approved by consensus.

IV. REVIEW/APPROVAL OF FEBRUARY 3, 2005 MEETING SUMMARY

The draft-meeting summary for February 3, 2005 PPC meeting was reviewed and approved by consensus.

V. PUBLIC COMMENT

- Elizabeth Mediano, APAIT, announced the 2005 API West Coast Regional Training on March 10th and March 11th in Anaheim, CA.
- Dani Mejia, APAIT, announced APAIT is looking for a Youth Health Educator/Part-Time Case Manager and applications can be downloaded from www.apaitonline.org.
- Peter Sykes, Hollywood SPA, announced AIDS Healthcare Foundation dropped Hollywood SPA (no longer providing HIV testing).

VI. Special Projects of National Significance (SPNS) PRESENTATION

Amy Wohl provided a power point presentation on the HRSA Special Project of National Significance (SPNS): Outreach, Care, and Prevention to Engage HIV Seropositive Young Men of Color Who Have Sex with men (YMCSM). Dr. Wohl announced the Los Angeles County Board of Supervisors has not approved the funding for this project, so view this presentation as a proposed project.

Introduction

- Improved programs are needed to increase HIV testing and disclosure among high-risk YMCSM and to encourage YMCSM to initiate and maintain HIV care.

- The Office of AIDS Programs and Policy, in collaboration with the HIV Epidemiology Program were funded by HRSA to implement and evaluate an innovative adaptation of outreach and case management services to bring previously undiagnosed HIV-infected YMCSM into care services.

Background

The Los Angeles Young Men's Survey, Phase 1 (1994-1997) Results – HIV Seroprevalence Among MSM Ages 15-22 by Race/Ethnicity (n=549)

	n	HIV+	Prevalence
African American	109	21	19%
Asian	30	4	13
Latino	225	20	9
Other	16	1	6
Caucasian	156	7	4

Overall HIV prevalence for this sample +10%. Of the 12 Native Americans and 1 Mixed Race participant in this sample, none were HIV positive.

The Los Angeles Young Men's Survey, Phase 2 (1998-2000) Results – HIV Seroprevalence Among MSM Ages 23-29 by Race/Ethnicity (n=449)

	n	HIV+	Prevalence
African American	44	11	25%
Latino	92	14	15
Other	29	3	10
Caucasian	225	17	8
Asian/Hawaiian/API	54	3	6

Overall HIV Prevalence for this sample = 11%. The 1 Native American participant was not HIV positive.

Methods

Specific Aims of YMCSM SPNS Project

- To determine if an integrated case management model increases utilization of services and retention of HIV care by HIV-infected YMSM not previously in regular care compared to standard case management.
- To evaluate differences in the two case management models with respect to risk behaviors, and virologic, immunologic and clinical outcomes of HIV disease.

Study Design

- Randomized Intervention trial
  - 270 HIV+ Latino and African American MSM ages 13-24 will be recruited
  - 2:1 randomization scheme will be used.
  - 180 to Integrated Case Management and 90 to Standard Case Management

Eligibility Criteria

- African American or Latino males
- Ages 13-24
- Recently received a positive HIV test result OR tested positive in the past and is not in care
- Had oral or anal sex with a male in the past 5 years

Recruitment

- Active Recruitment Methods:
  - Study Outreach Worker and Two Case Managers go with Mobile Test Van staff to recruit for YMCSM
  - Recruit for HIV testing/outreach at social venues during evenings and nights when YMCSM likely to attend
- Passive Recruitment Methods:
  - Coordinate with staff at HIV C & T sites for referral of HIV+ 13-24 year old YMCSM
  - Coordinate with staff at schools and CBOs that provide services to youth for referral of HIV+ 13-24 year old YMCSM

Objective of Outreach Component

- Goals of outreach efforts are to:
  - Help clients learn their HIV status, understand the risks of infection and the benefits of knowing one's status
  - Recruit clients for counseling and testing services
  - Provide assistance in accessing HIV care for those YMCSM who test positive
- Help clients understand the importance of accessing care early in the course of their HIV infection;
- Help clients understand the importance of accessing care regularly and consistently in order to monitor their HIV disease and the effects and efficacy of HAART;
- Help clients understand the importance of reducing risk behaviors and preventing HIV transmission to others;
- Help clients understand the importance of consistent HAART adherence to prevent disease progression and development of resistance.

Primary HIV Care/Case Management Site I – AltaMed Health Services

- Community based organization established in 1969;
- Located in the East SPA on Whittier Blvd. In Los Angeles;
- Sees approximately 1,000 HIV/AIDS patients per year;
- Patients predominantly male (87%) and Latino (80%); 13% African American;
- Approximately 3% of the patient population is aged 13-24

Primary HIV Care/Case Management Site II – OASIS Clinic

- Outpatient Alternative Service Intervention System (OASIS) Clinic
  - Part of King/Drew Medical Center and established in 1986;
  - Located in the South SPA on Wilmington Avenue in Los Angeles;
  - Provides care to approximately 950 HIV/AIDS patients per year
  - Patients predominantly male (72%), African American (66%) and Latino (28%);
  - Approximately 4% of the patient population is aged 13-24

Recruitment and Retention Challenges

- Many youth do not access care after testing positive;
- Many youth may be referred to care by CBOs and testing sites, however they may access care once or never;
- Project case managers will aim to develop rapport with clients during active recruitment testing phase;
- Project staff will try to introduce client to the case manager at time of testing;
- Recruitment/Hiring of Case Managers and Outreach Worker

Integrated case Management (ICM)

- A two-year comprehensive program that combines psychosocial, medical and prevention case management services.
- Clients will meet with the ICM weekly for the first 2 months; biweekly for the next 10 months; and monthly in the last year
- The ICM Case Manager will:
  - Develop an individualized plan with client
  - Link clients directly into medical outpatient care
  - Provide prevention case management
  - Make referrals to supportive services
- Clients will be transitioned to standard case management after 2 years

Standard Case Management (SCM) – Control Group

- HIV/AIDS psychosocial case management links clients to supportive services, substance abuse and mental health treatment, housing and other pressing needs;
- Clients meet at least monthly with the case manager;
- Clients are discharged from case management services when they no longer need them, they have moved or stop attending appointments or transfer to another agency

Evaluation of Efficacy of ICM and SCM Interventions – Data Collected

- Baseline data
  - Demographics, physical and mental health, adherence to care and ARV's, social support, sexual identity, sexual risk behaviors, partner disclosure, substance use, and condom use.

- Follow-up data
    - Adherence to care and ARVs, sexual identity, sexual risk behaviors, partner disclosure, substance use and condom use at 6, 12,18, 24, 30 and 36 months.
- Process data
    - Attendance to Case Manager and medical appointments, outreach and HCT referrals.
- Medical Chart Abstraction
    - Viral load, CD4 count, opportunistic infection, ARV's and death.
- Research/Evaluation Questions to Answer
    - Will clients in ICM have fewer missed clinic visits than clients in Standard Case Management (SCM)?
    - Will clients in ICM have lower viral loads, higher CD4 counts and fewer OIs at 6 and 12 months following study enrollment that clients in SCM?
    - Will clients in ICM be more likely to adhere to their HAART regimens than clients in SCM?
    - Will clients in ICM use condoms more often than clients in SCM at 6 and 12 months?
    - Will clients in ICM have more decreases in injection and non-injection drug use at 5 and 12 months than SCM clients?
- Multi-Site Evaluation
    - To be conducted by SPNS Evaluation Center at George Washington University in Washington, D.C.
        - Will identify which individual-level and program-level characteristics are associated with:
            - Improved outreach to YMCSM
            - Improved access to prevention services
            - Increased entry into and retention in care
            - HIV-related clinical and behavioral outcomes
        - To identify unique barriers to and facilitators into HIV care for this hard-to-reach population.
        - To identify clinical environments that are most effective at helping youth initiate and maintain HIV care.
- Staffing
    - Principal Investigator – HEP
        - Evaluation Manager
        - Research Assistant
        - Outreach Worker
    - OAPP
        - Project Manager
        - Supervising Case Manager
    - AltaMed and OASIS
        - Co-investigators
        - 2 Case Managers

A copy of the presentation is on file.

QUESTION: (Jeffrey King) What will you hope to be able to find out as a result of the extended period of time?
ANSWER: (Dr. Wohl) The participants in the Standard Case Management control group will remain in the intervention as long as the Case Manager feels it is necessary and we will continue to follow them for the same period of time as we follow the participants in the ICM model. We will continue to get risk behavior measures, CD4 counts, viral loads, and all of the other information and compare those at equal points (i.e. at 6 months, how are the individuals in the two different arms are doing, at 12 months who is doing better, etc.).

QUESTION: In Los Angeles County, there are very good adolescent HIV care providers, how does this fit into that? Are there good HIV adolescent care providers at AltaMed? And at the OASIS Clinic? I am wondering if we are doing sort of a disservice to the kids to force them to go to particular sites when we know there are very good HIV adolescent care providers out there and really what adolescent's need are adolescent care providers.

ANSWER: Yes, there are some really good HIV adolescent care providers out there and we are well aware of them. I think HRSA is interested in expanding the capacity to provide care to youth in Los Angeles County recognizing the strength of those existing programs and to try to develop training modules for the providers at OASIS and AltaMed who are accustomed to providing care to adults and not to adolescents.

QUESTION: Do you plan to look at whether or not their partners get tested? And if their partners are HIV infected, that they get into care? Both male and female, since your definition of sex with men is pretty broad, I would suspect that some of these kids maybe also having sex with women and they would need to be tested as well.
ANSWER: We will ask them whether or not they know the serostatus of their partner(s) and if their partner(s) have not been tested, we will encourage them to refer their partner(s) to us or other HIV testing sites, where they can get tested. We have those questions in our study instrument.

QUESTION: (Elizabeth Mendia) Are the Integrated Case Managers (ICMs) required to have a medical background, an RN or something of that sort, but you stated the ICMs would be peers?
ANSWER: We are open to anyone who is interested in these positions and if someone happens to have nurses training or medical background, which makes them a stronger candidate. What we have found in other projects we have done is they do not tend to be nurses.

QUESTION: (Elizabeth Mendia) The model that you developed for the ICM is that comparable to what has been done in other jurisdictions?
ANSWER: It is not widely done, this ICM. There is one report of a program (I believe in Chicago). Very few case management programs have been fully and well evaluated and that is what we are hoping to do here.

QUESTION: (Kathy Watt) This project is a 5-year study. With the OASIS Clinic being housed at King/Drew Medical Center and with the issues surrounding King/Drew Medical Center, what is the contingency plan or how are you going to address the 5-year study if King/Drew Medical Center is not accredited/closed?
ANSWER: I really don't think King/Drew Medical Center is going anywhere and I don't think the doors are going to be closed.

QUESTION: (Kathy Watt) They don't want to be seen going to the doctor in their neighborhood, so they don't go there, they travel. How are they going to break those norms?
ANSWER: Our staff will have to be able to address this issue, when clients bring this up.

QUESTION: (Jeffrey King) When you talk about adherence, how comprehensive of a program or component is there when it relates to adherence (e.g. support groups, monitoring)?
ANSWER: The outreach going on at the King/Drew Medial Center OASIS Clinic is impressive. In terms of the adherence component, we do not have the capacity to do "directly observed therapy" but we will have the case manager identify, up front, what a patient foresees as their obstacles to taking their meds.

QUESTION: (Jeff Bailey) In your flow chart at the very top, there is counseling and testing; however, I did not seen anywhere in your staffing pattern on who is providing the counseling and testing and I am curious of who that is?
ANSWER: We looked at the HIV counseling and testing data for Los Angeles and we have identified the sites who tested the most gay positive young men of color and we will be coordinating with those sites.

QUESTION: (Jeff Bailey) When do you anticipate the start up date for recruitment?
ANSWER: We are hoping May 2005/June 2005, so we are now in the development phase.

VII. HIV/EPI PRESENTATION

Dr. Douglas Frye, Office of Health Assessment and Epidemiology, presented a Power Point presentation titled the Los Angeles County 2004 Epidemiologic Profile of HIV and AIDS. Hard copies of the An Epidemiologic Profile of HIV and AIDS – Los Angeles County 2004 document were distributed.

The EPI Profile is a large part and the first part of the 2004-2008 Los Angeles County HIV Prevention Plan. Dr. Frye provided a brief summary of the profile.

Background

- The Centers for Disease Control and Prevention (CDC) requires an HIV/AIDS Epidemiological Profile every three to five years – previous 1995, 1999, 2000
- Provides information about HIV/AIDS in Los Angeles
    - Core surveillance data
    - HIV Epidemiology Program research
    - Other county-specific research
- Epi profile is used by other agencies to develop and improve HIV prevention and care services

EPI Profile is divided into 8 sections: introduction, description of Los Angeles County, HIV/AIDS Epi Trends in Los Angeles, Geographic Distribution of AIDS Cases, Behavioral Risk Groups, Special Needs Populations, Co-morbid Communicable Diseases and Care Services Utilization.

Description of Los Angeles County

- Large in population size (10,000,000 people) and square mileage (4,000 square miles)
- Greatest proportion of residents living in poverty among major United States major metropolitan areas
- Largest proportion of illiterate working age adults (over 50%)
- Largest county jail
- Challenges: overcrowding, homelessness, immigration and many languages, high percent without health insurance

Epidemiologic trends in HIV/AIDS in Los Angeles County

- Compared with the United States, higher proportion of HIV/AIDS cases in Los Angeles County Latino; MSM
- Annual numbers of AIDS cases declining among all racial/ethnic groups
- Rates remain relatively high for Blacks
- Blacks/Latinos: 3 of every 4 female cases
- Whites/Latinos: 3 of every 4 male cases
- Having sex with men the predominant mode of exposure for both men and women
- Pediatric HIV/AIDS cases continue to decline thanks to perinatal antiretroviral drug therapy
- Number of persons living with AIDS rising; now – 20,000+
- Estimate 50 – 60,000 persons living with HIV/AIDS in Los Angeles County
- 1 of 4 living with HIV/AIDS unaware of status
- Transgendered women and MSM highest HIV incidence at Counseling and Testing sites

Geographic Distribution of AIDS

- Among Service Planning Areas, SPA 4 (Metro) has highest number and highest proportion of persons living with AIDS (PLWA)
    - Hollywood areas has most PLWA: 5,800
    - West Hollywood has highest proportion of their residents living with AIDS: 2.7%
- SPA 8 (South Bay, including Long Beach) has second highest number living with AIDS
- SPA 1 (Antelope Valley) has lowest number

Behavioral Risk Groups (BRGs)

- The HIV Prevention Planning Committee recognize seven behavioral risk groups:
    - Transgendered persons and their partners
    - Men who have sex with men only (MSM)
    - Men who have sex with men and women (MSM/W)
    - MSM or MSM/W who also inject drugs
    - Heterosexual male injection drug users

- Female injection drug users
- Women at sexual risk

Special Needs Populations

- Estimated HIV seroprevalence of Commission on HIV/AIDS Health Services' Special Needs groups:

Transgendered Persons	17 %
MSM of Color	10 %
White MSM	9.5%
Injection Drug Users	3.7%
Homeless and Unstably Housed	3.5%
Recently Incarcerated	2.7%
Non-injection Drug Users	1.5%
Serious Mental Illness	0.9%
Undocumented Immigrants	0.3%
Women of Childbearing Age	0.2%
Youth	0.1%

Co-Morbid Diseases

- Tuberculosis (TB)
  - Among AIDS cases, higher odds of TB co-infection in Latinos, American Indians, Asians; IDU; foreign-born
- Syphilis
  - 50-70% of syphilis cases from 2001-2003 were in HIV-infected MSM
- Hepatitis C virus (HCV)
  - Among IDU, HCV infection rate (70%), but HIV/HCV co-infection rates low (3-4%)
  - Among IDU with AIDS, HCV co-infection 46-65%

Care Services Utilization

- Persons using AIDS Drug Assistance Program (ADAP) are predominately English-speaking White and Latino males with a public care provider, no health insurance, and income less than $18,000/year
- In SHAS, Latinos and Blacks living with AIDS had HIV diagnosed significantly later in the course of their disease than did Whites.
  - 72% of Latinos and 52% of Blacks living with AIDS were diagnosed with AIDS within a year of learning they were HIV-infected.
  - Half of Whites were diagnosed with AIDS at least 5 years prior to learning they were HIV-infected.

QUESTION: Is this information available on-line?
ANSWER: Yes on the HIV/EPI Program website.

QUESTION: (Richard Zaldivar) Under slide 6 which is the Special Needs Population for the Commission on HIV Health Services (CHHS), how did they arrive at that?
ANSWER: This is very complicated you can read the technical notes (a lot of estimates basically used a conglomerate of studies showing percentages and also estimating the population size). This is done for allocation purposes. There are a lot of footnotes and caveat's that go along with this data.

VIII. BREAK

IX. NOMINATIONS FOR COMMUNITY CO-CHAIR

Vanessa Talamantes announced that every year in March, the PPC opens the floor for the nomination of a Community Co-Chair. To maintain continuity, the Community Co-Chair seat is staggered. This year Jeff Bailey terms out. The Community Co-Chair seat has a term of two years. Vanessa Talamantes opened the floor for nominations for Community Co-Chair. Kathy Watt was nominated and accepted the nomination for PPC Community Co-Chair. The nomination will remain open for 30 days.

On behalf of the PPC, Vanessa Talamantes extended a "Thank You" to Jeff Bailey for all of this commitment and support to the PPC.

QUESTION: (Richard Zaldivar) When do the nominations close?
ANSWER: (Vanessa Talamantes) Next month.

X. COMMUNITY CO-CHAIRS REPORT

- UCHAPS Update – Jeff Bailey reported at the last UCHAPS Meeting, there was a discussion about the DEBI interventions and the trainings. The CDC announced there are over 5,000 people on the waiting list to be trained in the various DEBI interventions across the United States. The CDC did not anticipate the volume of responses from all the local health jurisdictions, so the CDC is trying to provide all of these trainings. The CDC announced there are three new additional DEBI interventions coming down. John Mesta announced (locally) OAPP has identified nine interventions where OAPP is coordinating trainings. There are three entities (training centers) that specifically train around specific interventions. OAPP will be taking an inventory of all the agencies, what trainings have been attended and who requires training.

  QUESTION: (Kathy Watt) Regarding the DEBI Interventions impact, for people who were funded to do DEBI's and they can't do DEBI because they have not done DEBI training, what impact does that have on prevention hitting-the-streets here? Until they get trained on DEBI, can they do other stuff? Or do they have to hold still or what?
  ANSWER: (Mario Pérez) There isn't anything in writing that requires a local contracted provider to be trained in the intervention that they have been funded to implement. I think what we have learned is there may have been quite a number of local programs who articulated some familiarity or expertise with a given intervention. Clearly, some of those interventions have been implemented locally for a number of years (EXAMPLE: POL, Mpowerment). When those proposals were funded, I think some providers said maybe I better get training because I may not be familiar with some of the core elements or some of the program indicators. In my opinion, there is nothing that should preclude a provider from implementing the intervention as they have proposed to the county and has the county has agreed to purchase.

- Update on Venue-Based Task Force – Jeff Bailey reported the Venue-Based Task Force Meeting was held last Thursday on February 24th and there was a very good turnout. The Venue-Based Task Force will continue to meet monthly after the PPC Executive Subcommittee Meeting.

  QUESTION: (David Giugni) What is the status of testing in Commercial Sex Venues?
  ANSWER: (Jeff Bailey) Services have been reinstated and OAPP has identified seven agencies to continue to provide services. The agencies have the option to say no but they have been given the opportunity to go into the venues and provide testing.

  QUESTION: (David Giugni) Is testing occurring now?
  ANSWER: (Jeff Bailey) In some venues, it never really stopped but there will be a process that agencies establish a MOU with the club that they are going to provide services so that there is an understanding between them and an expectation that the services will be provided and the venues will provide a space to do counseling and testing.

  Jeff Bailey reported a decision was made at the PPC Executive Subcommittee meeting that the April, 2005 PPC Meeting would be an Open House regardless if there is a change in the meeting structure by then. The April, 2005 PPC meeting will be an Open House where we will present the Prevention Plan and we will also do a quick view of the subcommittees, where people can get a taste of each subcommittee, then rotate to the next subcommittee.

  Jeff Bailey reported the PPC and CHHS co-chairs will continue to meet on a monthly basis to continue to identify strategies and effective ways to work together so than we are not duplicating efforts and can more effectively share our plans with one another.

XI. GOVERNMENTAL CO-CHAIR REPORT

Mario Pérez reported the Department of Health Services has proposed a set of seven HIV Counseling and Testing service providers to have their contracts amended to allow them to include testing in Commercial Sex Venues. The seven providers were identified to serve SPAs 2, 4 and 8. The scopes of work were amended a little differently in each instance to allow them about ¼ of their effort to take place in Commercial Sex Venues under the same fee structure that they had successful bid for. The Los Angeles County Board of Supervisors accepted those amendments and approved and now that those contracts have been forwarded to providers, OAPP can now take those contracts and amend them officially. At this point, providers and owners can begin to negotiate the delivery of services.

QUESTION: (David Giugni) What was the change regarding the funding?
ANSWER: (Mario Pérez) The County Board of Supervisors has approved an amendment to a contract that is in place for 2 years. There are no restrictions in terms of the timeframe in which testing services can be delivered in a commercial sex venue. Until we (OAPP) hear otherwise, we (OAPP) assume that those testing services will continue.

COMMENT: (Mario Pérez**)** Testing in commercial sex venues will account for about 1% of all the tests, if we move forward with the scopes of work, as amended. The Department of Health Services will rely on the Sexually Transmitted Diseases Program to also deliver HIV Counseling and Testing services in some of the venues.

QUESTION: (Chi-Wai Au) Can you identify the seven providers?
ANSWER: (Mario Perez) Valley Community Clinic and Tarzana Treatment Centers in SPA 2; GLC, AHF and AltaMed for SPA 4 and Cal State Long Beach and Bienestar in SPA 8.

COMMENT: (Jeff Bailey) One of the topics of discussion at the Venue-Based Task Force meeting was to identify what are effective strategies for people who do not want to test in those venues and linking them to other testing sites.

Mario Pérez announced the CDC is convening a 2 day meeting next week which will involve representatives from the County of Los Angeles Health Departments, five directly funded CBOs, two local CBA providers, members from the Orange County Health Department, members from the San Diego Health Department, and one representative from the State Office of AIDS to discuss strengthening partnerships.

John Mesta provided an update on the CDC Progress Report and Guidance. OAPP is awaiting the Guidance from the CDC and the commitment is to release this Guidance sixty days before the Annual Progress Report due date, which is May 15, 2005.

XII. SUB-COMMITTEE REPORTS

- **Operations –** Diane Brown reported the PPC Membership Application was updated at the last Operations Subcommittee Meeting. Ms. Brown distributed the document to PPC members for review and approval.
  QUESTION: (Chi-Wai Au) The mentoring program that the PPC is starting up, could there be more wording about it?
  ANSWER: (Diane Brown) O.K. We can add a one or two line description about what it would mean if the applicant checked yes.

  Diane Brown placed a motion on the floor to approve the PPC Membership Application with the description. The motion was second by Jeff Bailey. The motion to approve the PPC Membership Application with description was approved by consensus. Once the change is made to the PPC Membership Application, the PPC Membership Application will be made available. The PPC Operations subcommittee is developing a brochure to go along with the PPC Membership Application.

  Diane Brown reported Operations is reviewing and updating the PPC Policies and Procedures. A letter of resignation was received from Dr. Rose Veneigas.

QUESTION: (Vanessa Talamantes) Is there an update on the development of the Mentoring Program?
ANSWER: (Diane Brown) The Operations Subcommittee will develop guidelines, but once we get new members on board, the Executive Subcommittee would pair the new member with a veteran member (who is willing to participant in the mentoring program) assigned to the same subcommittee.

QUESTION: (Jeff Bailey) Are they any updates on the Youth Conference scheduled for April?
ANSWER: (Chi-Wai Au) The Youth Conference is scheduled for Wednesday, April 27th at Almansor Court. Registration forms are available on the back table.

- **Evaluation –** David Giugni reported the last Evaluation Subcommittee was on February 22nd. At that meeting, Mike Janson provided an update on the transcription of data for the Needs Assessment and Gaps Analysis. Less than 20% of the tapes have been transcribed, but transcription will be done much more quickly now that 2 staff from OAPP and 2 staff from HIV/EPI are transcribing tapes. It is anticipated that findings will be available for review at the Evaluation Subcommittee meeting in April.

  Two teams from the subcommittee have been reviewing the issue of prevention among heterosexual males whose risk for HIV infection is exclusively through sexual contact with women. One team is reviewing the EPI data and the other team is reviewing existing programs in place nationally that address this demographic. Each team gave reports at the last meeting. Additional information will be collected and reported to the subcommittee in our next meeting on March 22nd. If sufficient information is available at the time of the meeting, and if it appears that this demographic should be considered for prevention resources, we will begin to formulate draft recommendations that will be forwarded to the Executive Subcommittee.

- **Standards & Best Practices –** Jeff Bailey reported Dr. Rose Veniegas submitted her letter of resignation to the PPC; however, Dr. Veniegas indicated she will continue to participate on the Standards & Best Practices subcommittee. Additionally, Jeff Bailey has agreed to chair the Standards & Best Practices Subcommittee.

  There was a discussion on job descriptions at the last Standards & Best Practices Subcommittee and at the next meeting, the Standards & Best Practices Subcommittee should be finalizing recommendations that will be brought to the PPC around competencies (both minimum competencies and preferred competencies) for Health Educators, HIV Counseling and Testing, Prevention Case Management, PCRS and a wide range of recommendations around particular competencies. After that, the Standards & Best Practices Subcommittee will be examining prevention protocol.

  Jeff Bailey requested individuals to forward any ideas about additional staff training to the Standards and Best Practices Subcommittee.

  Jeff Bailey placed a motion on the floor to request approval to merge HIV Counseling and Testing Task Force into the Standards and Best Practices Subcommittee of the PPC. The motion was second by Kathy Watt. The motion to approve the merger of the HIV Counseling and Testing Task Force into the Standards & Best Practices Subcommittee of the PPC was approved by consensus.

- **Commission on HIV Health Services (CHHS) Report –** Elizabeth Mendia reported the CHHS met on February 10, 2005 and the customary reports were given. The CHHS accepted the PPC's recommendation regarding the three individuals nominated to fill the one non-voting PPC seat. The CHHS also endorsed the recommendation by the PPC for the two groups (PPC and CHHS) to periodically meet jointly.

  QUESTION: (Mario Pérez**)** Was there any discussion of the HIV Prevention Plan?
  ANSWER: (Kathy Watt) No.

XIII. ANNOUNCEMENTS

- David Giugni announced the City of West Hollywood will be hosting its 2nd Town Hall Forum on Crystal Meth and HIV on March 23, 2005 and flyers on the back table.
- Ricki Rosales, City of Los Angeles AIDS Coordinator's Office, announced the Commercial Sex Venue Initiative was heard in Committee on Tuesday and the motion passed. It should be going to City Council within the next few weeks.
- Mario Pérez announced OAPP has received the official results of the Title I Application and Los Angeles County scored the 2nd highest ranked application in the Country.
- Mario Pérez announced OAPP has received the results from the CDC Progress Report and there were no findings from the CDC.
- Chi-Wai Au reminded everyone to pick up the Youth Conference Registration forms (available on the back table).
- Kathy Watt announced the Drug and Alcohol Task Force conducted training on Reducing the Sexual Risks of MSM and based on a review of the evaluations, people are begging for more training.
- Chi-Wai Au announced the Sexually Transmitted Diseases Program has recently implemented a workshop for Syphilis Providers to help them be trained on MSM issues and substance abuse issues.
- Richard Zaldivar "thanked" Mario Pérez and OAPP for the Faith-Based contract, which has been extended until 2008.
- John Mesta provided an update of the printing of the Prevention Plan.

XIV. CLOSING ROLL CALL

XV. ADJOURNMENT – Meeting adjourned at 4:50 PM.
Note: All agenda items are subject to action.

MOTION AND VOTING SUMMARY		
MOTION: #1: Approve the Agenda order.	Passed by Consensus	**Motion Passed**
MOTION # 2: Approve the Meeting Summary from the February 3, 2005 Meeting with revisions.	Passed by Consensus	**Motion Passed**
MOTION #3: Open nominations for Community Co-Chair	Passed by Consensus	**Motion Passed**
MOTION #4: Approve PPC Membership Application	Passed by Consensus with the adding of the description of the Mentoring Program	**Motion Passed**
MOTION #5: Approve merge of HIV Counseling and Testing Task Force into the Standards & Best Practices Subcommittee of the PPC	Passed by Consensus	**Motion Passed**

NOTE: All HIV Prevention Planning Committee (PPC) meeting summaries, tapes and documents are available for review and inspection at the Office of AIDS Programs and Policy (OAPP) located at 600 South Commonwealth Avenue, 2nd Floor, Los Angeles, CA 90005. To make an appointment to review these documents, please call Cheryl Williams at (213) 351-8126.

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